



AFFILIATED COMMUNITY
HEALTH FOUNDATION

Supporting Health Careers in Our Communities.

MEDICAL STUDENT SCHOLARSHIP APPLICATION FORM

Return completed application form and two letters of reference by June 15, 2012 to:

Julayne Mayer

Physician Recruitment, Medical Rotations, Scholarships

Affiliated Community Medical Centers

101 Willmar Avenue SW, Willmar, MN 56201

Type or print all entries in ink.

1. Name: _____

2. Present address: _____

3. Present phone: _____

4. Permanent address: _____

5. Permanent phone: _____

6. Email: _____ 7. Birth date: _____

8. High School attended: _____ Graduation date: _____

9. College attended: _____ Graduation date: _____

10. College major: _____

11. Medical school attending: _____

Medical school address: _____

12. Anticipated year of graduation: _____

13. Anticipated residency specialty: _____

14. Geographic location you plan on working in upon completion of your residency: _____

15. Marital status: _____ Spouse/Significant other's occupation: _____

16. On a separate, attached page, please describe why you believe yourself to be a deserving candidate for this scholarship.

Signature of applicant: _____ Date: _____